

## NOTICE FOR ACTIVE EMPLOYEE MEDICAL PROGRAM ONLY: Disclosure of Grandfathered Status

LANS believes this Medical Program for **active employees and their covered family members** is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the employer or to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

# Summary of Benefits: PPO Program

Active EE PPO Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges	
	Preferred Provider <sup>1,2</sup> (In-Network)	NonPreferred Provider <sup>1,2</sup> (Out-of-Network)
<b>Calendar Year Deductible</b> <sup>1</sup> (Family deductible is an aggregate of three times the Individual amount and may be met by three or more family members.)	\$250 Individual/ \$750 Family	\$500 Individual/ \$1,500 Family
<b>Calendar Year Out-of-Pocket Limit</b> <sup>2</sup> (Includes deductible, copayments, and percentage coinsurance amounts <b>except</b> out-of-network inpatient hospital, residential treatment center, and drug plan copayments. Family limit may be met by three or more family members.)	\$3,000 Individual/ \$9,000 Family	\$6,000 Individual/ \$18,000 Family
<b>Lifetime Maximum Benefit Limit (per member)</b>	Unlimited	Unlimited
<b>Office Visit/Exam Charge</b> Office Visits/Exams or Consultations (Other office services received during the visit, unless specified otherwise, are subject to deductible and/or coinsurance provisions as listed in the rest of the summary. Includes initial visit to OB/Gyn or midwife to confirm pregnancy; pre-natal and post-natal care is listed under "Hospital/Other Facility: Inpatient" as part of global delivery fee.)	\$20/visit ( <i>deductible waived</i> )	40% after deductible
Family Planning: Office visit Sterilization/surgery (reversal not covered); other related services in office (IUD, diaphragm, Depo-Provera)	\$20/visit ( <i>deductible waived</i> ) 10% after deductible	40% after deductible
Allergy Injections (only) and Immunizations (only)	No copay ( <i>deductible waived</i> )	40% after deductible
Other Allergy Care (such as allergy testing; extract preparation)	10% after deductible	40% after deductible
Therapeutic Injections; Office Surgery and Supplies	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
Nutritional Counseling (3 sessions/life for certain conditions)	\$20/visit ( <i>deductible waived</i> )	40% after deductible
<b>Routine/Preventive Well-Baby Care (Through Age 2):</b> Including check-ups, routine screenings; routine laboratory tests; immunizations	No Copay ( <i>deductible waived</i> )	40% ( <i>deductible waived</i> )
<b>Routine/Preventive Well-Child Care (Ages 3-18):</b> Including routine physicals and exams, vision/hearing screenings; well-child care; immunizations	\$20/visit ( <i>deductible waived</i> )	40% after deductible
<b>Routine/Preventive Adult Care (Ages 19 and Older):</b> Including routine physicals and gynecological exams; routine colonoscopies; immunizations	\$20/visit ( <i>deductible waived</i> )	40% after deductible
<b>Routine/Preventive Lab, X-Ray, Other Testing (Ages 3 and Older):</b> Including routine Pap tests, mammograms, cholesterol tests, urinalysis, EKGs, etc.	No Copay ( <i>deductible waived</i> )	40% after deductible
<b>OTHER MEDICAL/SURGICAL SERVICES</b>		
<b>Acupuncture</b> (limited to 20 visits/year)	\$20/visit ( <i>deductible waived</i> )	40% after deductible
<b>Ambulance: Emergency Transport</b> (Air/ground ambulance, as needed)	10% after PPO deductible <sup>3</sup>	
<b>Ambulance: Nonemergency Ground Transfer</b> (between facilities)	10% after PPO deductible <sup>4</sup>	
<b>Ambulance: Nonemergency Air Transfer</b> (between facilities)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Cancer/Congenital Heart Disease Care</b> (Blue Distinction programs only include a lodging per diem benefit of \$50 per person, or \$100/day for 2-3 persons. Travel and the above per diem allowances combined are limited to \$10,000 per lifetime for each program utilized. If program is not used, benefits are same as for any other service, per place of treatment, provider contract and type of service.)	10% after deductible <sup>4,5</sup>	40% after deductible <sup>4,5</sup>
<b>Cardiac Rehabilitation, Outpatient/Office</b>	\$20/visit ( <i>deductible waived</i> ) <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Dental/Facial Accident<sup>3</sup>, Oral Surgery, TMJ/CMJ Services</b> (for limited, non-dental medical conditions; see a benefit booklet for details)	Usual benefit based on type/place of service <sup>4</sup>	40% after deductible <sup>3,4</sup>
<b>Emergency Room Visit</b> ( <i>emergency condition only</i> )	\$75/visit ( <i>deductible waived</i> ) <sup>3</sup>	
Physician and Other Professional Provider Charges	10% after PPO deductible <sup>3</sup>	
<b>Hearing-Related Services</b> -Office exams and evaluations; cochlear implant; auditory testing -Hearing aid services (maximum total benefit of \$2,200 during 36-month period, including fitting of hearing aid and ear molds)	10% after deductible	40% after deductible

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Active EE PPO Medical Program Covered Services and Limitations (continued)	Member's Share of Covered Charges	
	Preferred Provider <sup>1,2</sup> (In-Network)	NonPreferred Provider <sup>1,2</sup> (Out-of-Network)
<b>Home Health Care/Home I.V. Services</b> (Private duty nursing not covered; care must be from a licensed home health care agency): Home health care agency services and home I.V. services (Out-of-network limited to 100 visits/calendar year)	10% after deductible <sup>4</sup> 10% (deductible waived) <sup>4</sup>	40% after deductible <sup>4</sup> 40% (deductible waived) <sup>4</sup>
<b>Hospice Services</b> including bereavement counseling when such services are provided by hospice (Respite care limited to 10 days for each 6-month benefit period.)	10% (deductible waived) <sup>4</sup>	40% (deductible waived) <sup>4</sup>
<b>Hospital/Other Facility: Inpatient</b>		
- <b>Medical/Surgical Acute Care, Observation, Medical Detox, Maternity-Related</b> (including routine newborn nursery charges), and <b>Extended Stay (Nonroutine) for Covered Newborn:</b> Room and Board and Covered Ancillaries	10% after deductible <sup>5</sup>	\$250 + 40% after deductible <sup>5</sup>
- <b>Birth Center</b>	10% after deductible	40% after deductible
- <b>Skilled Nursing Facility</b> and <b>Inpatient Physical Rehabilitation</b> (max. 100 days per calendar year for preferred and nonpreferred combined; in addition, nonpreferred services cannot exceed 70 days per calendar year)	10% (deductible waived) <sup>5</sup>	40% (deductible waived) <sup>5</sup>
- <b>Inpatient Physician's Medical Visit or Consultation; Routine Inpatient OB/Gyn Global Delivery Fee</b> (includes pre-natal/post-natal care); <b>Inpatient Newborn Male Circumcision</b>	No copay (deductible waived)	40% after deductible
- <b>Inpatient Surgeon, Anesthesiologist, Radiologist, Pathologist, and Assistant Surgeon</b> (including maternity services that are not part of OB/Gyn global delivery fee and complications of pregnancy)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Hospital/Other Facility: Outpatient/Ambulatory Surgery Center</b> (Includes covered services, whether billed by facility or professional provider, including surgery, diagnostic tests, chemotherapy, dialysis, and radiation treatment.)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Lab, X-Ray, and Other Diagnostic Tests (nonpreventive)</b> Including MRI, CT Scans, and PET Scans; Sleep Studies; EKGs, etc. - <i>Office or Freestanding/Independent Facility or Outpatient Hospital</i>	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Short-Term Rehabilitation, Outpatient and Office</b> (Includes outpatient and office physical, occupational, and speech therapy services, each of which is limited to 20 visits/calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	\$20/visit (deductible waived) <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Spinal/Osteopathic Manipulation</b> (Max. 20 visits/calendar year)	\$20/visit (deductible waived)	40% after deductible
<b>Supplies, Durable Medical Equipment, Prosthetics, Orthotics</b> (Includes insulin pumps and pump supplies. Support hose limited to 6 pair/year. Mastectomy bras limited to 3/year. For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision.)	10% after deductible <sup>4,6</sup>	40% after deductible <sup>4,6</sup>
<b>Surgery: Outpatient Hospital, Ambulatory Surgery Facility, or Office:</b> including facility and related physician and other professional charges, such as surgeon, pathologist, radiologist, etc.)	10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Therapy: Chemotherapy, Dialysis, and Radiation</b> - <i>Office or Freestanding Clinic</i> - <i>Outpatient Hospital</i>	\$20/visit (deductible waived) <sup>4</sup> 10% after deductible <sup>4</sup>	40% after deductible <sup>4</sup>
<b>Transplant Services:</b> Limitations apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.	10% after deductible <sup>4,5</sup>	No benefit
<b>Travel and Lodging:</b> Benefits are available when these services are related to case-managed Cancer Services or Congenital Heart Disease if patient is receiving treatment from a Blue Distinction Center for Specialty Care or case-managed transplants (excluding cornea). Travel of more than 50 miles must be necessary in order to be eligible for coverage under this provision. For each of the three benefit programs, the benefits are as follows:		
- Travel to and from health care facility plus per diem payments listed below	\$10,000/lifetime after PPO deductible <sup>4</sup>	
- Lodging per diem for patient and/or companion(s)	\$50/individual or \$100 for 2-3 persons after PPO deductible <sup>4</sup>	
<b>Urgent Care Facility</b>	\$20/visit (deductible waived)	40% after deductible
- Ancillary Services (lab tests, x-rays, supplies, etc.)	10% after deductible	40% after deductible

See footnotes on next page

Active EE PPO Medical Program		Preferred Provider <sup>1,2</sup>	NonPreferred Provider <sup>1,2</sup>
Covered Services and Limitations (continued)		(In-Network)	(Out-of-Network)
<b>BEHAVIORAL HEALTH: Mental Health and Chemical Dependency</b>			
<b>Mental Health Services</b>			
<ul style="list-style-type: none"> <li>- Office, Outpatient, Intensive Outpatient Programs (IOP)</li> <li>- Inpatient and/or Partial Hospitalization</li> <li>- Related Physician Claims</li> </ul>		\$20/visit ( <i>deductible waived</i> ) <sup>4</sup> 10% after deductible <sup>5</sup> No copay ( <i>deductible waived</i> )	40% after deductible <sup>4</sup> \$250 + 40% after deductible <sup>5</sup> 40% after deductible
<b>Chemical Dependency Rehabilitation</b>			
<ul style="list-style-type: none"> <li>- Office, Outpatient, Intensive Outpatient Programs (IOP), Outpatient Suboxone</li> <li>- Inpatient and/or Partial Hospitalization</li> <li>- Related Physician Claims</li> <li>- Residential Treatment Center (max. 130 days/lifetime), including physician</li> </ul>		\$20/visit ( <i>deductible waived</i> ) <sup>4</sup> 10% after deductible <sup>5</sup> No copay ( <i>deductible waived</i> ) \$250 facility copay plus 20% after deductible <sup>5,7</sup>	40% after deductible <sup>4</sup> \$250 + 40% after deductible <sup>5</sup> 40% after deductible \$250 facility copay plus 40% after deductible <sup>5,7</sup>
<b>DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines<sup>8</sup></b>			
Enteral nutritional products, compounded medications, special medical foods, and other drugs require preauthorization or benefits will be denied.	<b>Generic Drug</b>	<b>Brand-Name Drug<sup>8</sup></b>	
		On Drug List	Not on Drug List
<b>Retail Pharmacy/Specialty Pharmacy Programs</b> (up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Zostavax vaccines, for which no copayment is required)	\$15	\$30	\$45
<b>Mail-Order Program</b> (up to a 60- or 90-day supply or 540 units, whichever is less)	\$30	\$60	\$90
<b>Nonprescription Enteral Nutritional Products and Special Medical Foods</b> (up to a 30-day supply per 30-day period; requires preauthorization)	\$45 retail/\$90 mail-order		

**FOOTNOTES:**

- All services – excluding items covered under the drug plan – are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., “deductible waived”). When applicable, the deductible must be met before benefit payments are made. Charges for Preferred Provider services do *not* cross-apply to the Nonpreferred Provider deductible, nor vice versa.
- After a member (or family) reaches the applicable out-of-pocket limit, the Medical Program pays 100 percent of that member’s (or family’s) covered charges for the rest of the calendar year (except for items covered under the drug plan, out-of-network inpatient hospital copayments, and residential treatment center copayments). Deductible, coinsurance, and copayments for Preferred Provider services do *not* cross-apply to the Nonpreferred Provider limit, nor vice versa.
- Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. Follow-up treatment from a Nonpreferred Provider and treatment that is not for an emergency is paid at the Nonpreferred Provider level.
- Certain services are **not covered** if preauthorization is not obtained from BCBSNM (or the BCBSNM Behavioral Health Unit). A list of services requiring preauthorization and a description of when obtaining preauthorization is **your** responsibility is in Section 4 of the PPO Medical Program benefit booklet. Some services may require a written request for preauthorization in order to be covered. (Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.) See Section 4 in the benefit booklet for details.
- Preauthorization is required for inpatient admissions. You pay a **\$300 penalty** for covered facility services if preauthorization is your responsibility and is not obtained. Some services, such as transplants and physical rehabilitation, require additional preauthorization. If you do not receive preauthorization for these individually identified procedures, benefits for any related admissions will be denied. (The \$300 penalty will not apply in such cases.)
- Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.
- Extended care facilities (such as nursing homes and residential treatment centers) are **excluded** from coverage. However, LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, up to **130 days** of residential treatment center services for patients being treated for chemical dependency. This is a lifetime maximum that accrues from Medical Program to Medical Program and is the only exception that can be made to the extended care facility exclusion.
- Prescription drugs and other items covered under the drug plan must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy or Mail-Order Programs. (BCBSNM has contracted with a separate program for administration of your outpatient drug plan benefits.) Some prescription drugs require preauthorization before coverage will be available. If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the generic drug copayment.

**Deductibles, copayments, and coinsurance percentages are applied to BCBSNM’s covered charges, which may be less than the provider’s billed charges. Preferred Providers will not charge you the difference between the covered charge and the billed charge for covered services; Nonpreferred Providers may.**